DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS

FOURTH EDITION

TEXT REVISION

DSM-IV-TR™

Published by the
American Psychiatric Association
Washington, DC

Manufactured in the United States of America on acid-free paper.

American Psychiatric Association
1400 K Street, N.W., Washington, DC 20005
www.psych.org

The correct citation for this book is American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision. Washington, DC, American Psychiatric Association, 2000.

Library of Congress Cataloging-in-Publication Data
Diagnostic and statistical manual of mental disorders : DSM-IV.—4th ed., text revision.
p. ; cm.
Prepared by the Task Force on DSM-IV and other committees and work groups of the American Psychiatric Association.
Includes index.
ISBN 0-89042-024-6 (casebound : alk. paper)—ISBN 0-89042-025-4 (pbk. : alk. paper)
1. Mental illness—Classification—Handbooks, manuals, etc. 2. Mental illness—Diagnosis—Handbooks, manuals, etc. I. Title: DSM-IV. II. American Psychiatric Association. III. American Psychiatric Association. Task Force on DSM-IV.
[DNLM: 1. Mental Disorders—classification. 2. Mental Disorders—diagnosis.
WM 15 D536 2000]
RC455.2.C4 D536 2000
616.89'075—dc21
00-024852

British Library Cataloguing in Publication Data
A CIP record is available from the British Library.

Text Design—Anne Barnes
Manufacturing—R. R. Donnelley & Sons Company

TASK FORCE ON DSM-IV

ALLEN FRANCES, M.D.
Chairperson

HAROLD ALAN PINCUS, M.D.
Vice-Chairperson

MICHAEL B. FIRST, M.D.
Editor, Text and Criteria

Nancy Coover Andreasen, M.D., Ph.D.
David H. Barlow, Ph.D.
Magda Campbell, M.D.
Dennis P. Cantwell, M.D.
Ellen Frank, Ph.D.
Judith H. Gold, M.D.
John Gunderson, M.D.
Robert E. Hales, M.D.
Kenneth S. Kendler, M.D.
David J. Kupfer, M.D.
Michael R. Liebowitz, M.D.
Juan Enrique Mezzich, M.D., Ph.D.
Peter E. Nathan, Ph.D.
Roger Peele, M.D.
Darrel A. Regier, M.D., M.P.H.
A. John Rush, M.D.
Chester W. Schmidt, M.D.
Marc Alan Schuckit, M.D.
David Shaffer, M.D.
Robert L. Spitzer, M.D.
Special Adviser
Gary J. Tucker, M.D.
B. Timothy Walsh, M.D.
Thomas A. Widiger, Ph.D.
Research Coordinator
Janet B. W. Williams, D.S.W.
John C. Urbaitis, M.D.
Assembly Liaison
James J. Hudziak, M.D.
Resident Fellow (1990–1993)
Junius Gonzales, M.D.
Resident Fellow (1988–1990)

Ruth Ross, M.A.
Science Editor
Nancy E. Vettorello, M.U.P.
Administrative Coordinator
Wendy Wakefield Davis, Ed.M.
Editorial Coordinator
Cindy D. Jones
Administrative Assistant
Nancy Sydnor-Greenberg, M.A.
Administrative Consultant
Myriam Kline, M.S.
Focused Field-Trial Coordinator
James W. Thompson, M.D., M.P.H.
Videotape Field-Trial Coordinator

The DSM-IV Text Revision Work Groups are listed on pp. xv–xvii.

Anxiety Disorders Work Group

Michael R. Liebowitz, M.D.
Chairperson
David H. Barlow, Ph.D.
Vice-Chairperson
James C. Ballenger, M.D.
Jonathan Davidson, M.D.
Edna Foa, Ph.D.
Abby Fyer, M.D.

Delirium, Dementia, and Amnestic and Other Cognitive Disorders Work Group

Gary J. Tucker, M.D.
Chairperson
Michael Popkin, M.D.
Vice-Chairperson
Eric Douglas Caine, M.D.
Marshall Folstein, M.D.
Gary Lloyd Gottlieb, M.D.
Igor Grant, M.D.
Benjamin Liptzin, M.D.

Disorders Usually First Diagnosed During Infancy, Childhood, or Adolescence Work Group

David Shaffer, M.D.
Co-Chairperson
Magda Campbell, M.D.
Co-Chairperson
Susan J. Bradley, M.D.
Dennis P. Cantwell, M.D.
Gabrielle A. Carlson, M.D.
Donald Jay Cohen, M.D.
Barry Garfinkel, M.D.
Rachel Klein, Ph.D.
Benjamin Lahey, Ph.D.
Rolf Loeber, Ph.D.
Jeffrey Newcorn, M.D.
Rhea Paul, Ph.D.
Judith H. L. Rapoport, M.D.
Sir Michael Rutter, M.D.
Fred Volkmar, M.D.
John S. Werry, M.D.

Eating Disorders Work Group

B. Timothy Walsh, M.D.
Chairperson
Paul Garfinkel, M.D.
Katherine A. Halmi, M.D.
James Mitchell, M.D.
G. Terence Wilson, Ph.D.

Mood Disorders Work Group

A. John Rush, M.D.
Chairperson
Martin B. Keller, M.D.
Vice-Chairperson
Mark S. Bauer, M.D.
David Dunner, M.D.
Ellen Frank, Ph.D.
Donald F. Klein, M.D.

Multiaxial Issues Work Group

Janet B. W. Williams, D.S.W.
Chairperson
Howard H. Goldman, M.D., Ph.D.
Vice-Chairperson
Alan M. Gruenberg, M.D.
Juan Enrique Mezzich, M.D., Ph.D.
Roger Peele, M.D.
Stephen Setterberg, M.D.
Andrew Edward Skodol II, M.D.

Personality Disorders Work Group

John Gunderson, M.D.
Chairperson
Robert M. A. Hirschfeld, M.D.
Vice-Chairperson
Roger Blashfield, Ph.D.
Susan Jean Fiester, M.D.
Theodore Millon, Ph.D.
Bruce Pfohl, M.D.
Tracie Shea, Ph.D.
Larry Siever, M.D.
Thomas A. Widiger, Ph.D.

Premenstrual Dysphoric Disorder Work Group

Judith H. Gold, M.D.
Chairperson
Jean Endicott, Ph.D.
Barbara Parry, M.D.
Sally Severino, M.D.
Nada Logan Stotland, M.D.
Ellen Frank, Ph.D.
Consultant

Psychiatric Systems Interface Disorders (Adjustment, Dissociative, Factitious, Impulse-Control, and Somatoform Disorders and Psychological Factors Affecting Medical Conditions) Work Group

Robert E. Hales, M.D.
Chairperson
C. Robert Cloninger, M.D.
Vice-Chairperson
Jonathan F. Borus, M.D.
Jack Denning Burke, Jr., M.D., M.P.H.
Joe P. Fagan, M.D.
Steven A. King, M.D.
Ronald L. Martin, M.D.
Katharine Anne Phillips, M.D.
David A. Spiegel, M.D.
Alan Stoudemire, M.D.
James J. Strain, M.D.
Michael G. Wise, M.D.

Schizophrenia and Other Psychotic Disorders Work Group

Nancy Coover Andreasen, M.D., Ph.D.
Chairperson
John M. Kane, M.D.
Vice-Chairperson
Samuel Keith, M.D.
Kenneth S. Kendler, M.D.
Thomas McGlashan, M.D.

Sexual Disorders Work Group

Chester W. Schmidt, M.D.
Chairperson
Raul Schiavi, M.D.
Leslie Schover, Ph.D.
Taylor Seagraves, M.D.
Thomas Nathan Wise, M.D.

Sleep Disorders Work Group

David J. Kupfer, M.D.
Chairperson
Charles F. Reynolds III, M.D.
Vice-Chairperson
Daniel Buysse, M.D.
Roger Peele, M.D.
Quentin Regestein, M.D.
Michael Sateia, M.D.
Michael Thorpy, M.D.

Substance-Related Disorders Work Group

Marc Alan Schuckit, M.D.
Chairperson
John E. Helzer, M.D.
Vice-Chairperson
Linda B. Cottler, Ph.D.
Thomas Crowley, M.D.
Peter E. Nathan, Ph.D.
George E. Woody, M.D.

Committee on Psychiatric Diagnosis and Assessment

Layton McCurdy, M.D.
Chairperson (1987–1994)
Kenneth Z. Altshuler, M.D. (1987–1992)
Thomas F. Anders, M.D. (1988–1994)
Susan Jane Blumenthal, M.D. (1990–1993)
Leah Joan Dickstein, M.D. (1988–1991)
Lewis J. Judd, M.D. (1988–1994)
Gerald L. Klerman, M.D. (deceased) (1988–1991)
Stuart C. Yudofsky, M.D. (1992–1994)
Jack D. Blaine, M.D.
Consultant (1987–1992)
Jerry M. Lewis, M.D.
Consultant (1988–1994)
Daniel J. Luchins, M.D.
Consultant (1987–1991)
Katharine Anne Phillips, M.D.
Consultant (1992–1994)
Cynthia Pearl Rose, M.D.
Consultant (1990–1994)
Louis Alan Moench, M.D.
Assembly Liaison (1991–1994)
Steven K. Dobscha, M.D.
Resident Fellow (1990–1992)
Mark Zimmerman, M.D.
Resident Fellow (1992–1994)

Joint Committee of the Board of Trustees and Assembly of District Branches on Issues Related to DSM-IV

Ronald A. Shellow, M.D.
Chairperson
Harvey Bluestone, M.D.
Leah Joan Dickstein, M.D.
Arthur John Farley, M.D.
Carol Ann Bernstein, M.D.

WORK GROUPS FOR THE DSM-IV TEXT REVISION

MICHAEL B. FIRST, M.D.
Co-Chairperson and Editor

HAROLD ALAN PINCUS, M.D.
Co-Chairperson

Laurie E. McQueen, M.S.S.W.
DSM Project Manager
Yoshie Satake, B.A.
DSM Program Coordinator

Anxiety Disorders Text Revision Work Group

Murray B. Stein, M.D.
Chairperson
Jonathan Abramowitz, Ph.D.
Gordon Asmundson, Ph.D.
Jean C. Beckham, Ph.D.
Timothy Brown, Ph.D., Psy.D.
Michelle Craske, Ph.D.
Edna Foa, Ph.D.
Thomas Mellman, M.D.
Ron Norton, Ph.D.
Franklin Schneier, M.D.
Richard Zinbarg, Ph.D.

Delirium, Dementia, and Amnestic and Other Cognitive Disorders and Mental Disorders Due to a General Medical Condition Text Revision Work Group

Eric Douglas Caine, M.D.
Jesse Fann, M.D., M.P.H.

Disorders Usually First Diagnosed During Infancy, Childhood, or Adolescence Text Revision Work Group

David Shaffer, M.D.
Chairperson
Donald J. Cohen, M.D.
Stephen Hinshaw, Ph.D.
Rachel G. Klein, Ph.D.
Ami Klin, Ph.D.
Daniel Pine, M.D.
Mark A. Riddle, M.D.
Fred R. Volkmar, M.D.
Charles Zeanah, M.D.

Eating Disorders Text Revision Work Group

Katharine L. Loeb, Ph.D.
B. Timothy Walsh, M.D.

Medication-Induced Movement Disorders Text Revision Work Group

Gerard Addonizio, M.D.
Lenard Adler, M.D.
Burton Angrist, M.D.
Daniel Casey, M.D.
Alan Gelenberg, M.D.
James Jefferson, M.D.
Dilip Jeste, M.D.
Peter Weiden, M.D.

Multiaxial Assessment

A multiaxial system involves an assessment on several axes, each of which refers to a different domain of information that may help the clinician plan treatment and predict outcome. There are five axes included in the DSM-IV multiaxial classification:

Axis I	Clinical Disorders
	Other Conditions That May Be a Focus of Clinical Attention
Axis II	Personality Disorders
	Mental Retardation
Axis III	General Medical Conditions
Axis IV	Psychosocial and Environmental Problems
Axis V	Global Assessment of Functioning

The use of the multiaxial system facilitates comprehensive and systematic evaluation with attention to the various mental disorders and general medical conditions, psychosocial and environmental problems, and level of functioning that might be overlooked if the focus were on assessing a single presenting problem. A multiaxial system provides a convenient format for organizing and communicating clinical information, for capturing the complexity of clinical situations, and for describing the heterogeneity of individuals presenting with the same diagnosis. In addition, the multiaxial system promotes the application of the biopsychosocial model in clinical, educational, and research settings.

The rest of this section provides a description of each of the DSM-IV axes. In some settings or situations, clinicians may prefer not to use the multiaxial system. For this reason, guidelines for reporting the results of a DSM-IV assessment without applying the formal multiaxial system are provided at the end of this section.

Axis I: Clinical Disorders
Other Conditions That May Be a Focus of Clinical Attention

Axis I is for reporting all the various disorders or conditions in the Classification except for the Personality Disorders and Mental Retardation (which are reported on Axis II). The major groups of disorders to be reported on Axis I are listed in the box below. Also reported on Axis I are Other Conditions That May Be a Focus of Clinical Attention.

When an individual has more than one Axis I disorder, all of these should be reported (for examples, see p. 35). If more than one Axis I disorder is present, the principal diagnosis or the reason for visit (see p. 3) should be indicated by listing it first. When an individual has both an Axis I and an Axis II disorder, the principal diagnosis or the

reason for visit will be assumed to be on Axis I unless the Axis II diagnosis is followed by the qualifying phrase "(Principal Diagnosis)" or "(Reason for Visit)." If no Axis I disorder is present, this should be coded as V71.09. If an Axis I diagnosis is deferred, pending the gathering of additional information, this should be coded as 799.9.

Axis I
Clinical Disorders
Other Conditions That May Be a Focus of Clinical Attention

Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence
(*excluding Mental Retardation, which is diagnosed on Axis II*)
Delirium, Dementia, and Amnestic and Other Cognitive Disorders
Mental Disorders Due to a General Medical Condition
Substance-Related Disorders
Schizophrenia and Other Psychotic Disorders
Mood Disorders
Anxiety Disorders
Somatoform Disorders
Factitious Disorders
Dissociative Disorders
Sexual and Gender Identity Disorders
Eating Disorders
Sleep Disorders
Impulse-Control Disorders Not Elsewhere Classified
Adjustment Disorders
Other Conditions That May Be a Focus of Clinical Attention

Axis II: Personality Disorders Mental Retardation

Axis II is for reporting Personality Disorders and Mental Retardation. It may also be used for noting prominent maladaptive personality features and defense mechanisms. The listing of Personality Disorders and Mental Retardation on a separate axis ensures that consideration will be given to the possible presence of Personality Disorders and Mental Retardation that might otherwise be overlooked when attention is directed to the usually more florid Axis I disorders. The coding of Personality Disorders on Axis II should not be taken to imply that their pathogenesis or range of appropriate treatment is fundamentally different from that for the disorders coded on Axis I. The disorders to be reported on Axis II are listed in the box below.

In the common situation in which an individual has more than one Axis II diagnosis, all should be reported (for examples, see p. 35). When an individual has both an Axis I and an Axis II diagnosis and the Axis II diagnosis is the principal diagnosis or the reason for visit, this should be indicated by adding the qualifying phrase "(Principal Diagnosis)" or "(Reason for Visit)" after the Axis II diagnosis. If no Axis II disorder is present, this should be coded as V71.09. If an Axis II diagnosis is deferred, pending the gathering of additional information, this should be coded as 799.9.

Axis II may also be used to indicate prominent maladaptive personality features that do not meet the threshold for a Personality Disorder (in such instances, no code number should be used—see Example 3 on p. 37). The habitual use of maladaptive defense mechanisms may also be indicated on Axis II (see Appendix B, p. 811, for definitions and Example 1 on p. 37).

Axis II
Personality Disorders
Mental Retardation

Paranoid Personality Disorder	Narcissistic Personality Disorder
Schizoid Personality Disorder	Avoidant Personality Disorder
Schizotypal Personality Disorder	Dependent Personality Disorder
Antisocial Personality Disorder	Obsessive-Compulsive Personality Disorder
Borderline Personality Disorder	Personality Disorder Not Otherwise Specified
Histrionic Personality Disorder	Mental Retardation

Axis III: General Medical Conditions

Axis III is for reporting current general medical conditions that are potentially relevant to the understanding or management of the individual's mental disorder. These conditions are classified outside the "Mental Disorders" chapter of ICD-9-CM (and outside Chapter V of ICD-10). A listing of the broad categories of general medical conditions is given in the box below. (For a more detailed listing including the specific ICD-9-CM codes, refer to Appendix G.)

As discussed in the "Introduction," the multiaxial distinction among Axis I, Axis II, and Axis III disorders does not imply that there are fundamental differences in their conceptualization, that mental disorders are unrelated to physical or biological factors or processes, or that general medical conditions are unrelated to behavioral or psychosocial factors or processes. The purpose of distinguishing general medical conditions is to encourage thoroughness in evaluation and to enhance communication among health care providers.

General medical conditions can be related to mental disorders in a variety of ways. In some cases it is clear that the general medical condition is directly etiological to the development or worsening of mental symptoms and that the mechanism for this effect is physiological. When a mental disorder is judged to be a direct physiological consequence of the general medical condition, a Mental Disorder Due to a General Medical Condition should be diagnosed on Axis I and the general medical condition should be recorded on both Axis I and Axis III. For example, when hypothyroidism is a direct cause of depressive symptoms, the designation on Axis I is 293.83 Mood Disorder Due to Hypothyroidism, With Depressive Features, and the hypothyroidism is listed again and coded on Axis III as 244.9 (see Example 3, p. 37). For a further discussion, see p. 181.

In those instances in which the etiological relationship between the general medical condition and the mental symptoms is insufficiently clear to warrant an Axis I diagnosis of Mental Disorder Due to a General Medical Condition, the appropriate mental disorder (e.g., Major Depressive Disorder) should be listed and coded on Axis I; the general medical condition should only be coded on Axis III.

There are other situations in which general medical conditions are recorded on Axis III because of their importance to the overall understanding or treatment of the individual with the mental disorder. An Axis I disorder may be a psychological reaction to an Axis III general medical condition (e.g., the development of 309.0 Adjustment Disorder With Depressed Mood as a reaction to the diagnosis of carcinoma of the breast). Some general medical conditions may not be directly related to the mental disorder but nonetheless have important prognostic or treatment implications (e.g., when the diagnosis on Axis I is 296.30 Major Depressive Disorder, Recurrent, and on Axis III is 427.9 arrhythmia, the choice of pharmacotherapy is influenced by the general medical condition; or when a person with diabetes mellitus is admitted to the hospital for an exacerbation of Schizophrenia and insulin management must be monitored).

When an individual has more than one clinically relevant Axis III diagnosis, all should be reported. For examples, see p. 35. If no Axis III disorder is present, this should be indicated by the notation "Axis III: None." If an Axis III diagnosis is deferred, pending the gathering of additional information, this should be indicated by the notation "Axis III: Deferred."

Axis III

General Medical Conditions (with ICD-9-CM codes)

Infectious and Parasitic Diseases (001–139)
Neoplasms (140–239)
Endocrine, Nutritional, and Metabolic Diseases and Immunity Disorders (240–279)
Diseases of the Blood and Blood-Forming Organs (280–289)
Diseases of the Nervous System and Sense Organs (320–389)
Diseases of the Circulatory System (390–459)
Diseases of the Respiratory System (460–519)
Diseases of the Digestive System (520–579)
Diseases of the Genitourinary System (580–629)
Complications of Pregnancy, Childbirth, and the Puerperium (630–676)
Diseases of the Skin and Subcutaneous Tissue (680–709)
Diseases of the Musculoskeletal System and Connective Tissue (710–739)
Congenital Anomalies (740–759)
Certain Conditions Originating in the Perinatal Period (760–779)
Symptoms, Signs, and Ill-Defined Conditions (780–799)
Injury and Poisoning (800–999)

Axis IV: Psychosocial and Environmental Problems

Axis IV is for reporting psychosocial and environmental problems that may affect the diagnosis, treatment, and prognosis of mental disorders (Axes I and II). A psychosocial or environmental problem may be a negative life event, an environmental difficulty or deficiency, a familial or other interpersonal stress, an inadequacy of social support or personal resources, or other problem relating to the context in which a person's difficulties have developed. So-called positive stressors, such as job promotion, should be listed only if they constitute or lead to a problem, as when a person has difficulty adapting to the new situation. In addition to playing a role in the initiation or exacerbation of a mental disorder, psychosocial problems may also develop as a consequence of a person's psychopathology or may constitute problems that should be considered in the overall management plan.

When an individual has multiple psychosocial or environmental problems, the clinician may note as many as are judged to be relevant. In general, the clinician should note only those psychosocial and environmental problems that have been present during the year preceding the current evaluation. However, the clinician may choose to note psychosocial and environmental problems occurring prior to the previous year if these clearly contribute to the mental disorder or have become a focus of treatment—for example, previous combat experiences leading to Posttraumatic Stress Disorder.

In practice, most psychosocial and environmental problems will be indicated on Axis IV. However, when a psychosocial or environmental problem is the primary focus of clinical attention, it should also be recorded on Axis I, with a code derived from the section "Other Conditions That May Be a Focus of Clinical Attention" (see p. 731).

For convenience, the problems are grouped together in the following categories:

- **Problems with primary support group**—e.g., death of a family member; health problems in family; disruption of family by separation, divorce, or estrangement; removal from the home; remarriage of parent; sexual or physical abuse; parental overprotection; neglect of child; inadequate discipline; discord with siblings; birth of a sibling
- **Problems related to the social environment**—e.g., death or loss of friend; inadequate social support; living alone; difficulty with acculturation; discrimination; adjustment to life-cycle transition (such as retirement)
- **Educational problems**—e.g., illiteracy; academic problems; discord with teachers or classmates; inadequate school environment
- **Occupational problems**—e.g., unemployment; threat of job loss; stressful work schedule; difficult work conditions; job dissatisfaction; job change; discord with boss or co-workers
- **Housing problems**—e.g., homelessness; inadequate housing; unsafe neighborhood; discord with neighbors or landlord
- **Economic problems**—e.g., extreme poverty; inadequate finances; insufficient welfare support
- **Problems with access to health care services**—e.g., inadequate health care services; transportation to health care facilities unavailable; inadequate health insurance

- **Problems related to interaction with the legal system/crime**—e.g., arrest; incarceration; litigation; victim of crime
- **Other psychosocial and environmental problems**—e.g., exposure to disasters, war, other hostilities; discord with nonfamily caregivers such as counselor, social worker, or physician; unavailability of social service agencies

When using the Multiaxial Evaluation Report Form (see p. 36), the clinician should identify the relevant categories of psychosocial and environmental problems and indicate the specific factors involved. If a recording form with a checklist of problem categories is not used, the clinician may simply list the specific problems on Axis IV. (See examples on p. 35.)

Axis IV
Psychosocial and Environmental Problems

Problems with primary support group
Problems related to the social environment
Educational problems
Occupational problems
Housing problems
Economic problems
Problems with access to health care services
Problems related to interaction with the legal system/crime
Other psychosocial and environmental problems

Axis V: Global Assessment of Functioning

Axis V is for reporting the clinician's judgment of the individual's overall level of functioning. This information is useful in planning treatment and measuring its impact, and in predicting outcome.

The reporting of overall functioning on Axis V can be done using the Global Assessment of Functioning (GAF) Scale. The GAF Scale may be particularly useful in tracking the clinical progress of individuals in global terms, using a single measure. The GAF Scale is to be rated with respect only to psychological, social, and occupational functioning. The instructions specify, "Do not include impairment in functioning due to physical (or environmental) limitations."

The GAF scale is divided into 10 ranges of functioning. Making a GAF rating involves picking a single value that best reflects the individual's overall level of functioning. The description of each 10-point range in the GAF scale has two components: the first part covers symptom severity, and the second part covers functioning. The GAF rating is within a particular decile if **either** the symptom severity **or** the level of functioning falls within the range. For example, the first part of the range 41–50 describes "serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting)" and the second part includes "any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job)." It should be noted

that in situations where the individual's symptom severity and level of functioning are discordant, the final GAF rating always reflects the worse of the two. For example, the GAF rating for an individual who is a significant danger to self but is otherwise functioning well would be below 20. Similarly, the GAF rating for an individual with minimal psychological symptomatology but significant impairment in functioning (e.g., an individual whose excessive preoccupation with substance use has resulted in loss of job and friends but no other psychopathology) would be 40 or lower.

In most instances, ratings on the GAF Scale should be for the current period (i.e., the level of functioning at the time of the evaluation) because ratings of current functioning will generally reflect the need for treatment or care. In order to account for day-to-day variability in functioning, the GAF rating for the "current period" is sometimes operationalized as the lowest level of functioning for the past week. In some settings, it may be useful to note the GAF Scale rating both at time of admission and at time of discharge. The GAF Scale may also be rated for other time periods (e.g., the highest level of functioning for at least a few months during the past year). The GAF Scale is reported on Axis V as follows: "GAF = ," followed by the GAF rating from 0 to 100, followed by the time period reflected by the rating in parentheses—for example, "(current)," "(highest level in past year)," "(at discharge)." (See examples on p. 35.)

In order to ensure that no elements of the GAF scale are overlooked when a GAF rating is being made, the following method for determining a GAF rating may be applied:

STEP 1: Starting at the top level, evaluate each range by asking "is **either** the individual's symptom severity OR level of functioning worse than what is indicated in the range description?"

STEP 2: Keep moving down the scale until the range that best matches the individual's symptom severity OR the level of functioning is reached, **whichever is worse.**

STEP 3: Look at the next lower range as a double-check against having stopped prematurely. This range should be too severe on **both** symptom severity **and** level of functioning. If it is, the appropriate range has been reached (continue with step 4). If not, go back to step 2 and continue moving down the scale.

STEP 4: To determine the specific GAF rating within the selected 10-point range, consider whether the individual is functioning at the higher or lower end of the 10-point range. For example, consider an individual who hears voices that do not influence his behavior (e.g., someone with long-standing Schizophrenia who accepts his hallucinations as part of his illness). If the voices occur relatively infrequently (once a week or less), a rating of 39 or 40 might be most appropriate. In contrast, if the individual hears voices almost continuously, a rating of 31 or 32 would be more appropriate.

In some settings, it may be useful to assess social and occupational disability and to track progress in rehabilitation independent of the severity of the psychological symptoms. For this purpose, a proposed Social and Occupational Functioning Assessment Scale (SOFAS) (see p. 817) is included in Appendix B. Two additional proposed scales that may be useful in some settings—the Global Assessment of Relational Functioning (GARF) Scale (see p. 814) and the Defensive Functioning Scale (see p. 807)—are also included in Appendix B.

Global Assessment of Functioning (GAF) Scale

Consider psychological, social, and occupational functioning on a hypothetical continuum of mental health–illness. Do not include impairment in functioning due to physical (or environmental) limitations.

Code (Note: Use intermediate codes when appropriate, e.g., 45, 68, 72.)

100 | 91 **Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.**

90 | 81 **Absent or minimal symptoms** (e.g., mild anxiety before an exam), **good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns** (e.g., an occasional argument with family members).

80 | 71 **If symptoms are present, they are transient and expectable reactions to psychosocial stressors** (e.g., difficulty concentrating after family argument); **no more than slight impairment in social, occupational, or school functioning** (e.g., temporarily falling behind in schoolwork).

70 | 61 **Some mild symptoms** (e.g., depressed mood and mild insomnia) **OR some difficulty in social, occupational, or school functioning** (e.g., occasional truancy, or theft within the household), **but generally functioning pretty well, has some meaningful interpersonal relationships.**

60 | 51 **Moderate symptoms** (e.g., flat affect and circumstantial speech, occasional panic attacks) **OR moderate difficulty in social, occupational, or school functioning** (e.g., few friends, conflicts with peers or co-workers).

50 | 41 **Serious symptoms** (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) **OR any serious impairment in social, occupational, or school functioning** (e.g., no friends, unable to keep a job).

40 | 31 **Some impairment in reality testing or communication** (e.g., speech is at times illogical, obscure, or irrelevant) **OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood** (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).

30 | 21 **Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment** (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) **OR inability to function in almost all areas** (e.g., stays in bed all day; no job, home, or friends).

20 | 11 **Some danger of hurting self or others** (e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement) **OR occasionally fails to maintain minimal personal hygiene** (e.g., smears feces) **OR gross impairment in communication** (e.g., largely incoherent or mute).

10 | 1 **Persistent danger of severely hurting self or others** (e.g., recurrent violence) **OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.**

0 Inadequate information.

The rating of overall psychological functioning on a scale of 0–100 was operationalized by Luborsky in the Health-Sickness Rating Scale (Luborsky L: "Clinicians' Judgments of Mental Health." *Archives of General Psychiatry* 7:407–417, 1962). Spitzer and colleagues developed a revision of the Health-Sickness Rating Scale called the Global Assessment Scale (GAS) (Endicott J, Spitzer RL, Fleiss JL, Cohen J: "The Global Assessment Scale: A Procedure for Measuring Overall Severity of Psychiatric Disturbance." *Archives of General Psychiatry* 33:766–771, 1976). A modified version of the GAS was included in DSM-III-R as the Global Assessment of Functioning (GAF) Scale.

Examples of How to Record Results of a DSM-IV Multiaxial Evaluation

Example 1:

Axis I	296.23	Major Depressive Disorder, Single Episode, Severe Without Psychotic Features
	305.00	Alcohol Abuse
Axis II	301.6	Dependent Personality Disorder
		Frequent use of denial
Axis III		None
Axis IV		Threat of job loss
Axis V	GAF = 35 (current)	

Example 2:

Axis I	300.4	Dysthymic Disorder
	315.00	Reading Disorder
Axis II	V71.09	No diagnosis
Axis III	382.9	Otitis media, recurrent
Axis IV		Victim of child neglect
Axis V	GAF = 53 (current)	

Example 3:

Axis I	293.83	Mood Disorder Due to Hypothyroidism, With Depressive Features
Axis II	V71.09	No diagnosis, histrionic personality features
Axis III	244.9	Hypothyroidism
	365.23	Chronic angle-closure glaucoma
Axis IV		None
Axis V	GAF = 45 (on admission)	
	GAF = 65 (at discharge)	

Example 4:

Axis I	V61.10	Partner Relational Problem
Axis II	V71.09	No diagnosis
Axis III		None
Axis IV		Unemployment
Axis V	GAF = 83 (highest level past year)	

Mood Episodes

Major Depressive Episode

Episode Features

The essential feature of a Major Depressive Episode is a period of at least 2 weeks during which there is either depressed mood or the loss of interest or pleasure in nearly all activities. In children and adolescents, the mood may be irritable rather than sad. The individual must also experience at least four additional symptoms drawn from a list that includes changes in appetite or weight, sleep, and psychomotor activity; decreased energy; feelings of worthlessness or guilt; difficulty thinking, concentrating, or making decisions; or recurrent thoughts of death or suicidal ideation, plans, or attempts. To count toward a Major Depressive Episode, a symptom must either be newly present or must have clearly worsened compared with the person's preepisode status. The symptoms must persist for most of the day, nearly every day, for at least 2 consecutive weeks. The episode must be accompanied by clinically significant distress or impairment in social, occupational, or other important areas of functioning. For some individuals with milder episodes, functioning may appear to be normal but requires markedly increased effort.

The mood in a Major Depressive Episode is often described by the person as depressed, sad, hopeless, discouraged, or "down in the dumps" (Criterion A1). In some cases, sadness may be denied at first, but may subsequently be elicited by interview (e.g., by pointing out that the individual looks as if he or she is about to cry). In some individuals who complain of feeling "blah," having no feelings, or feeling anxious, the presence of a depressed mood can be inferred from the person's facial expression and demeanor. Some individuals emphasize somatic complaints (e.g., bodily aches and pains) rather than reporting feelings of sadness. Many individuals report or exhibit increased irritability (e.g., persistent anger, a tendency to respond to events with angry outbursts or blaming others, or an exaggerated sense of frustration over minor matters). In children and adolescents, an irritable or cranky mood may develop rather than a sad or dejected mood. This presentation should be differentiated from a "spoiled child" pattern of irritability when frustrated.

Loss of interest or pleasure is nearly always present, at least to some degree. Individuals may report feeling less interested in hobbies, "not caring anymore," or not feeling any enjoyment in activities that were previously considered pleasurable (Criterion A2). Family members often notice social withdrawal or neglect of pleasurable avocations (e.g., a formerly avid golfer no longer plays, a child who used to enjoy soccer finds excuses not to practice). In some individuals, there is a significant reduction from previous levels of sexual interest or desire.

Appetite is usually reduced, and many individuals feel that they have to force themselves to eat. Other individuals, particularly those encountered in ambulatory settings, may have increased appetite and may crave specific foods (e.g., sweets or other carbohydrates). When appetite changes are severe (in either direction), there

may be a significant loss or gain in weight, or, in children, a failure to make expected weight gains may be noted (Criterion A3).

The most common sleep disturbance associated with a Major Depressive Episode is insomnia (Criterion A4). Individuals typically have middle insomnia (i.e., waking up during the night and having difficulty returning to sleep) or terminal insomnia (i.e., waking too early and being unable to return to sleep). Initial insomnia (i.e., difficulty falling asleep) may also occur. Less frequently, individuals present with oversleeping (hypersomnia) in the form of prolonged sleep episodes at night or increased daytime sleep. Sometimes the reason that the individual seeks treatment is for the disturbed sleep.

Psychomotor changes include agitation (e.g., the inability to sit still, pacing, handwringing; or pulling or rubbing of the skin, clothing, or other objects) or retardation (e.g., slowed speech, thinking, and body movements; increased pauses before answering; speech that is decreased in volume, inflection, amount, or variety of content, or muteness) (Criterion A5). The psychomotor agitation or retardation must be severe enough to be observable by others and not represent merely subjective feelings.

Decreased energy, tiredness, and fatigue are common (Criterion A6). A person may report sustained fatigue without physical exertion. Even the smallest tasks seem to require substantial effort. The efficiency with which tasks are accomplished may be reduced. For example, an individual may complain that washing and dressing in the morning are exhausting and take twice as long as usual.

The sense of worthlessness or guilt associated with a Major Depressive Episode may include unrealistic negative evaluations of one's worth or guilty preoccupations or ruminations over minor past failings (Criterion A7). Such individuals often misinterpret neutral or trivial day-to-day events as evidence of personal defects and have an exaggerated sense of responsibility for untoward events. For example, a realtor may become preoccupied with self-blame for failing to make sales even when the market has collapsed generally and other realtors are equally unable to make sales. The sense of worthlessness or guilt may be of delusional proportions (e.g., an individual who is convinced that he or she is personally responsible for world poverty). Blaming oneself for being sick and for failing to meet occupational or interpersonal responsibilities as a result of the depression is very common and, unless delusional, is not considered sufficient to meet this criterion.

Many individuals report impaired ability to think, concentrate, or make decisions (Criterion A8). They may appear easily distracted or complain of memory difficulties. Those in intellectually demanding academic or occupational pursuits are often unable to function adequately even when they have mild concentration problems (e.g., a computer programmer who can no longer perform complicated but previously manageable tasks). In children, a precipitous drop in grades may reflect poor concentration. In elderly individuals with a Major Depressive Episode, memory difficulties may be the chief complaint and may be mistaken for early signs of a dementia ("pseudodementia"). When the Major Depressive Episode is successfully treated, the memory problems often fully abate. However, in some individuals, particularly elderly persons, a Major Depressive Episode may sometimes be the initial presentation of an irreversible dementia.

Frequently there may be thoughts of death, suicidal ideation, or suicide attempts (Criterion A9). These thoughts range from a belief that others would be better off if

the person were dead, to transient but recurrent thoughts of committing suicide, to actual specific plans of how to commit suicide. The frequency, intensity, and lethality of these thoughts can be quite variable. Less severely suicidal individuals may report transient (1- to 2-minute), recurrent (once or twice a week) thoughts. More severely suicidal individuals may have acquired materials (e.g., a rope or a gun) to be used in the suicide attempt and may have established a location and time when they will be isolated from others so that they can accomplish the suicide. Although these behaviors are associated statistically with suicide attempts and may be helpful in identifying a high-risk group, many studies have shown that it is not possible to predict accurately whether or when a particular individual with depression will attempt suicide. Motivations for suicide may include a desire to give up in the face of perceived insurmountable obstacles or an intense wish to end an excruciatingly painful emotional state that is perceived by the person to be without end.

A diagnosis of a Major Depressive Episode is not made if the symptoms meet criteria for a Mixed Episode (Criterion B). A Mixed Episode is characterized by the symptoms of both a Manic Episode and a Major Depressive Episode occurring nearly every day for at least a 1-week period.

The degree of impairment associated with a Major Depressive Episode varies, but even in mild cases, there must be either clinically significant distress or some interference in social, occupational, or other important areas of functioning (Criterion C). If impairment is severe, the person may lose the ability to function socially or occupationally. In extreme cases, the person may be unable to perform minimal self-care (e.g., feeding or clothing self) or to maintain minimal personal hygiene.

A careful interview is essential to elicit symptoms of a Major Depressive Episode. Reporting may be compromised by difficulties in concentrating, impaired memory, or a tendency to deny, discount, or explain away symptoms. Information from additional informants can be especially helpful in clarifying the course of current or prior Major Depressive Episodes and in assessing whether there have been any Manic or Hypomanic Episodes. Because Major Depressive Episodes can begin gradually, a review of clinical information that focuses on the worst part of the current episode may be most likely to detect the presence of symptoms. The evaluation of the symptoms of a Major Depressive Episode is especially difficult when they occur in an individual who also has a general medical condition (e.g., cancer, stroke, myocardial infarction, diabetes). Some of the criterion items of a Major Depressive Episode are identical to the characteristic signs and symptoms of general medical conditions (e.g., weight loss with untreated diabetes, fatigue with cancer). Such symptoms should count toward a Major Depressive Episode except when they are clearly and fully accounted for by a general medical condition. For example, weight loss in a person with ulcerative colitis who has many bowel movements and little food intake should not be counted toward a Major Depressive Episode. On the other hand, when sadness, guilt, insomnia, or weight loss are present in a person with a recent myocardial infarction, each symptom would count toward a Major Depressive Episode because these are not clearly and fully accounted for by the physiological effects of a myocardial infarction. Similarly, when symptoms are clearly due to mood-incongruent delusions or hallucinations (e.g., a 30-pound weight loss related to not eating because of a delusion that one's food is being poisoned), these symptoms do not count toward a Major Depressive Episode.

By definition, a Major Depressive Episode is not due to the direct physiological effects of a drug of abuse (e.g., in the context of Alcohol Intoxication or Cocaine Withdrawal), to the side effects of medications or treatments (e.g., steroids), or to toxin exposure. Similarly, the episode is not due to the direct physiological effects of a general medical condition (e.g., hypothyroidism) (Criterion D). Moreover, if the symptoms begin within 2 months of the loss of a loved one and do not persist beyond these 2 months, they are generally considered to result from Bereavement (see p. 740), unless they are associated with marked functional impairment or include morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation (Criterion E).

Associated Features and Disorders

Associated descriptive features and mental disorders. Individuals with a Major Depressive Episode frequently present with tearfulness, irritability, brooding, obsessive rumination, anxiety, phobias, excessive worry over physical health, and complaints of pain (e.g., headaches or joint, abdominal, or other pains). During a Major Depressive Episode, some individuals have Panic Attacks that occur in a pattern that meets criteria for Panic Disorder. In children, separation anxiety may occur. Some individuals note difficulty in intimate relationships, less satisfying social interactions, or difficulties in sexual functioning (e.g., anorgasmia in women or erectile dysfunction in men). There may be marital problems (e.g., divorce), occupational problems (e.g., loss of job), academic problems (e.g., truancy, school failure), Alcohol or Other Substance Abuse, or increased utilization of medical services. The most serious consequence of a Major Depressive Episode is attempted or completed suicide. Suicide risk is especially high for individuals with psychotic features, a history of previous suicide attempts, a family history of completed suicides, or concurrent substance use. There may also be an increased rate of premature death from general medical conditions. Major Depressive Episodes often follow psychosocial stressors (e.g., the death of a loved one, marital separation, divorce). Childbirth may precipitate a Major Depressive Episode, in which case the specifier With Postpartum Onset is noted (see p. 422).

Associated laboratory findings. No laboratory findings that are diagnostic of a Major Depressive Episode have been identified. However, a variety of laboratory findings have been noted to be abnormal more often in groups of individuals with Major Depressive Episodes compared with control subjects. It appears that the same laboratory abnormalities are associated with a Major Depressive Episode regardless of whether the episode is part of a Major Depressive, Bipolar I, or Bipolar II Disorder. Most laboratory abnormalities are state dependent (i.e., affected by the presence or absence of depressive symptoms), but some findings may precede the onset of the episode or persist after its remission. Laboratory tests are more likely to be abnormal in episodes with melancholic or psychotic features and in more severely depressed individuals.

Sleep EEG abnormalities may be evident in 40%–60% of outpatients and in up to 90% of inpatients with a Major Depressive Episode. The most frequently associated polysomnographic findings include 1) sleep continuity disturbances, such as prolonged sleep latency, increased intermittent wakefulness, and early morning awakening; 2) reduced non–rapid eye movement (NREM) stages 3 and 4 sleep (slow-wave sleep), with a shift in slow-wave activity away from the first NREM period; 3) decreased rapid eye movement (REM) latency (i.e., shortened duration of the first NREM period); 4) increased phasic REM activity (i.e., the number of actual eye movements during REM); and 5) increased duration of REM sleep early in the night. There is evidence that these sleep abnormalities may persist after clinical remission or precede the onset of the initial Major Depressive Episode among those at high risk for a Mood Disorder (e.g., first-degree family members of individuals with Major Depressive Disorder).

The pathophysiology of a Major Depressive Episode may involve a dysregulation of a number of neurotransmitter systems, including the serotonin, norepinephrine, dopamine, acetylcholine, and gamma-aminobutyric acid systems. There is also evidence of alterations of several neuropeptides, including corticotropin-releasing hormone. In some depressed individuals, hormonal disturbances have been observed, including elevated glucocorticoid secretion (e.g., elevated urinary free cortisol levels or dexamethasone nonsuppression of plasma cortisol) and blunted growth hormone, thyroid-stimulating hormone, and prolactin responses to various challenge tests. Functional brain imaging studies document alterations in cerebral blood flow and metabolism in some individuals, including increased blood flow in limbic and paralimbic regions and decreased blood flow in the lateral prefrontal cortex. Depression beginning in late life is associated with alterations in brain structure, including periventricular vascular changes. None of these changes are present in all individuals in a Major Depressive Episode, however, nor is any particular disturbance specific to depression.

Specific Culture, Age, and Gender Features

Culture can influence the experience and communication of symptoms of depression. Underdiagnosis or misdiagnosis can be reduced by being alert to ethnic and cultural specificity in the presenting complaints of a Major Depressive Episode. For example, in some cultures, depression may be experienced largely in somatic terms, rather than with sadness or guilt. Complaints of "nerves" and headaches (in Latino and Mediterranean cultures), of weakness, tiredness, or "imbalance" (in Chinese and Asian cultures), of problems of the "heart" (in Middle Eastern cultures), or of being "heartbroken" (among Hopi) may express the depressive experience. Such presentations combine features of the Depressive, Anxiety, and Somatoform Disorders. Cultures also may differ in judgments about the seriousness of experiencing or expressing dysphoria (e.g., irritability may provoke greater concern than sadness or withdrawal). Culturally distinctive experiences (e.g., fear of being hexed or bewitched, feelings of "heat in the head" or crawling sensations of worms or ants, or vivid feelings of being visited by those who have died) must be distinguished from actual hallucinations or delusions that may be part of a Major Depressive Episode, With Psychotic Features. It is also imperative that the clinician not routinely dismiss a symptom merely because it is viewed as the "norm" for a culture.

The core symptoms of a Major Depressive Episode are the same for children and adolescents, although there are data that suggest that the prominence of characteristic

symptoms may change with age. Certain symptoms such as somatic complaints, irritability, and social withdrawal are particularly common in children, whereas psychomotor retardation, hypersomnia, and delusions are less common in prepuberty than in adolescence and adulthood. In prepubertal children, Major Depressive Episodes occur more frequently in conjunction with other mental disorders (especially Disruptive Behavior Disorders, Attention-Deficit Disorders, and Anxiety Disorders) than in isolation. In adolescents, Major Depressive Episodes are frequently associated with Disruptive Behavior Disorders, Attention-Deficit Disorders, Anxiety Disorders, Substance-Related Disorders, and Eating Disorders. In elderly adults, cognitive symptoms (e.g., disorientation, memory loss, and distractibility) may be particularly prominent.

Women are at significantly greater risk than men to develop Major Depressive Episodes at some point during their lives, with the greatest differences found in studies conducted in the United States and Europe. This increased differential risk emerges during adolescence and may coincide with the onset of puberty. Thereafter, a significant proportion of women report a worsening of the symptoms of a Major Depressive Episode several days before the onset of menses. Studies indicate that depressive episodes occur twice as frequently in women as in men. See the corresponding sections of the texts for Major Depressive Disorder (p. 372), Bipolar I Disorder (p. 385), and Bipolar II Disorder (p. 394) for specific information on gender.

Course

Symptoms of a Major Depressive Episode usually develop over days to weeks. A prodromal period that may include anxiety symptoms and mild depressive symptoms may last for weeks to months before the onset of a full Major Depressive Episode. The duration of a Major Depressive Episode is also variable. An untreated episode typically lasts 4 months or longer, regardless of age at onset. In a majority of cases, there is complete remission of symptoms, and functioning returns to the premorbid level. In a significant proportion of cases (perhaps 20%–30%), some depressive symptoms insufficient to meet full criteria for a Major Depressive Episode may persist for months to years and may be associated with some disability or distress (in which case the specifier In Partial Remission may be noted; p. 412). Partial remission following a Major Depressive Episode appears to be predictive of a similar pattern after subsequent episodes. In some individuals (5%–10%), the full criteria for a Major Depressive Episode continue to be met for 2 or more years (in which case the specifier Chronic may be noted; see p. 417).

Differential Diagnosis

A Major Depressive Episode must be distinguished from a **Mood Disorder Due to a General Medical Condition.** The appropriate diagnosis would be Mood Disorder Due to a General Medical Condition if the mood disturbance is judged to be the direct physiological consequence of a specific general medical condition (e.g., multiple sclerosis, stroke, hypothyroidism) (see p. 401). This determination is based on the history, laboratory findings, or physical examination. If both a Major Depressive Episode and a general medical condition are present but it is judged that the depressive symptoms

are not the direct physiological consequence of the general medical condition, then the primary Mood Disorder is recorded on Axis I (e.g., Major Depressive Disorder) and the general medical condition is recorded on Axis III (e.g., myocardial infarction). This would be the case, for example, if the Major Depressive Episode is considered to be the psychological consequence of having the general medical condition or if there is no etiological relationship between the Major Depressive Episode and the general medical condition.

A **Substance-Induced Mood Disorder** is distinguished from a Major Depressive Episode by the fact that a substance (e.g., a drug of abuse, a medication, or a toxin) is judged to be etiologically related to the mood disturbance (see p. 405). For example, depressed mood that occurs only in the context of withdrawal from cocaine would be diagnosed as Cocaine-Induced Mood Disorder, With Depressive Features, With Onset During Withdrawal.

In elderly persons, it is often difficult to determine whether cognitive symptoms (e.g., disorientation, apathy, difficulty concentrating, memory loss) are better accounted for by a **dementia** or by a Major Depressive Episode. A thorough medical evaluation and an evaluation of the onset of the disturbance, temporal sequencing of depressive and cognitive symptoms, course of illness, and treatment response are helpful in making this determination. The premorbid state of the individual may help to differentiate a Major Depressive Episode from a dementia. In a dementia, there is usually a premorbid history of declining cognitive function, whereas the individual with a Major Depressive Episode is much more likely to have a relatively normal premorbid state and abrupt cognitive decline associated with the depression.

Major Depressive Episodes with prominent irritable mood may be difficult to distinguish from **Manic Episodes with irritable mood** or from **Mixed Episodes.** This distinction requires a careful clinical evaluation of the presence of manic symptoms. If criteria are met for both a Manic Episode and a Major Depressive Episode (except for the 2-week duration) nearly every day for at least a 1-week period, this would constitute a Mixed Episode.

Distractibility and low frustration tolerance can occur in both **Attention-Deficit/Hyperactivity Disorder** and a Major Depressive Episode; if the criteria are met for both, Attention-Deficit/Hyperactivity Disorder may be diagnosed in addition to the Mood Disorder. However, the clinician must be cautious not to overdiagnose a Major Depressive Episode in children with Attention-Deficit/Hyperactivity Disorder whose disturbance in mood is characterized by irritability rather than by sadness or loss of interest.

A Major Depressive Episode that occurs in response to a psychosocial stressor is distinguished from **Adjustment Disorder With Depressed Mood** by the fact that the full criteria for a Major Depressive Episode are not met in Adjustment Disorder. After the loss of a loved one, even if depressive symptoms are of sufficient duration and number to meet criteria for a Major Depressive Episode, they should be attributed to **Bereavement** rather than to a Major Depressive Episode, unless they persist for more than 2 months or include marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

Finally, **periods of sadness** are inherent aspects of the human experience. These periods should not be diagnosed as a Major Depressive Episode unless criteria are met for severity (i.e., five out of nine symptoms), duration (i.e., most of the day, nearly

every day for at least 2 weeks), and clinically significant distress or impairment. The diagnosis **Depressive Disorder Not Otherwise Specified** may be appropriate for presentations of depressed mood with clinically significant impairment that do not meet criteria for duration or severity.

Criteria for Major Depressive Episode

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

(1) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). **Note:** In children and adolescents, can be irritable mood.
(2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
(3) significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. **Note:** In children, consider failure to make expected weight gains.
(4) insomnia or hypersomnia nearly every day
(5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
(6) fatigue or loss of energy nearly every day
(7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
(8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
(9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

B. The symptoms do not meet criteria for a Mixed Episode (see p. 365).

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

E. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

Manic Episode

Episode Features

A Manic Episode is defined by a distinct period during which there is an abnormally and persistently elevated, expansive, or irritable mood. This period of abnormal mood must last at least 1 week (or less if hospitalization is required) (Criterion A). The mood disturbance must be accompanied by at least three additional symptoms from a list that includes inflated self-esteem or grandiosity, decreased need for sleep, pressure of speech, flight of ideas, distractibility, increased involvement in goal-directed activities or psychomotor agitation, and excessive involvement in pleasurable activities with a high potential for painful consequences. If the mood is irritable (rather than elevated or expansive), at least four of the above symptoms must be present (Criterion B). The symptoms do not meet criteria for a Mixed Episode, which is characterized by the symptoms of both a Manic Episode and a Major Depressive Episode occurring nearly every day for at least a 1-week period (Criterion C). The disturbance must be sufficiently severe to cause marked impairment in social or occupational functioning or to require hospitalization, or it is characterized by the presence of psychotic features (Criterion D). The episode must not be due to the direct physiological effects of a drug of abuse, a medication, other somatic treatments for depression (e.g., electroconvulsive therapy or light therapy), or toxin exposure. The episode must also not be due to the direct physiological effects of a general medical condition (e.g., multiple sclerosis, brain tumor) (Criterion E).

The elevated mood of a Manic Episode may be described as euphoric, unusually good, cheerful, or high. Although the person's mood may initially have an infectious quality for the uninvolved observer, it is recognized as excessive by those who know the person well. The expansive quality of the mood is characterized by unceasing and indiscriminate enthusiasm for interpersonal, sexual, or occupational interactions. For example, the person may spontaneously start extensive conversations with strangers in public places, or a salesperson may telephone strangers at home in the early morning hours to initiate sales. Although elevated mood is considered the prototypical symptom, the predominant mood disturbance may be irritability, particularly when the person's wishes are thwarted. Lability of mood (e.g., the alternation between euphoria and irritability) is frequently seen.

Inflated self-esteem is typically present, ranging from uncritical self-confidence to marked grandiosity, and may reach delusional proportions (Criterion B1). Individuals may give advice on matters about which they have no special knowledge (e.g., how to run the United Nations). Despite lack of any particular experience or talent, the individual may embark on writing a novel or composing a symphony or seek publicity for some impractical invention. Grandiose delusions are common (e.g., having a special relationship to God or to some public figure from the political, religious, or entertainment world).

Almost invariably, there is a decreased need for sleep (Criterion B2). The person usually awakens several hours earlier than usual, feeling full of energy. When the sleep disturbance is severe, the person may go for days without sleep and yet not feel tired.

Manic speech is typically pressured, loud, rapid, and difficult to interrupt (Criterion B3). Individuals may talk nonstop, sometimes for hours on end, and without regard for others' wishes to communicate. Speech is sometimes characterized by joking, punning, and amusing irrelevancies. The individual may become theatrical, with dramatic mannerisms and singing. Sounds rather than meaningful conceptual relationships may govern word choice (i.e., clanging). If the person's mood is more irritable than expansive, speech may be marked by complaints, hostile comments, or angry tirades.

The individual's thoughts may race, often at a rate faster than can be articulated (Criterion B4). Some individuals with Manic Episodes report that this experience resembles watching two or three television programs simultaneously. Frequently there is flight of ideas evidenced by a nearly continuous flow of accelerated speech, with abrupt changes from one topic to another. For example, while talking about a potential business deal to sell computers, a salesperson may shift to discussing in minute detail the history of the computer chip, the industrial revolution, or applied mathematics. When flight of ideas is severe, speech may become disorganized and incoherent.

Distractibility (Criterion B5) is evidenced by an inability to screen out irrelevant external stimuli (e.g., the interviewer's tie, background noises or conversations, or furnishings in the room). There may be a reduced ability to differentiate between thoughts that are germane to the topic and thoughts that are only slightly relevant or clearly irrelevant.

The increase in goal-directed activity often involves excessive planning of, and excessive participation in, multiple activities (e.g., sexual, occupational, political, religious) (Criterion B6). Increased sexual drive, fantasies, and behavior are often present. The person may simultaneously take on multiple new business ventures without regard for the apparent risks or the need to complete each venture satisfactorily. Almost invariably, there is increased sociability (e.g., renewing old acquaintances or calling friends or even strangers at all hours of the day or night), without regard to the intrusive, domineering, and demanding nature of these interactions. Individuals often display psychomotor agitation or restlessness by pacing or by holding multiple conversations simultaneously (e.g., by telephone and in person at the same time). Some individuals write a torrent of letters on many different topics to friends, public figures, or the media.

Expansiveness, unwarranted optimism, grandiosity, and poor judgment often lead to an imprudent involvement in pleasurable activities such as buying sprees, reckless driving, foolish business investments, and sexual behavior unusual for the person, even though these activities are likely to have painful consequences (Criterion B7). The individual may purchase many unneeded items (e.g., 20 pairs of shoes, expensive antiques) without the money to pay for them. Unusual sexual behavior may include infidelity or indiscriminate sexual encounters with strangers.

The impairment resulting from the disturbance must be severe enough to cause marked impairment in functioning or to require hospitalization to protect the individual from the negative consequences of actions that result from poor judgment (e.g., financial losses, illegal activities, loss of employment, assaultive behavior). By definition, the presence of psychotic features during a Manic Episode constitutes marked impairment in functioning (Criterion D).

Symptoms like those seen in a Manic Episode may be due to the direct effects of

antidepressant medication, electroconvulsive therapy, light therapy, or medication prescribed for other general medical conditions (e.g., corticosteroids). Such presentations are not considered Manic Episodes and do not count toward the diagnosis of Bipolar I Disorder. For example, if a person with recurrent Major Depressive Disorder develops manic symptoms following a course of antidepressant medication, the episode is diagnosed as a Substance-Induced Mood Disorder, With Manic Features, and there is no switch from a diagnosis of Major Depressive Disorder to Bipolar I Disorder. Some evidence suggests that there may be a bipolar "diathesis" in individuals who develop manic-like episodes following somatic treatment for depression. Such individuals may have an increased likelihood of future Manic, Mixed, or Hypomanic Episodes that are not related to substances or somatic treatments for depression. This may be an especially important consideration in children and adolescents.

Associated Features and Disorders

Associated descriptive features and mental disorders. Individuals with a Manic Episode frequently do not recognize that they are ill and resist efforts to be treated. They may travel impulsively to other cities, losing contact with relatives and caretakers. They may change their dress, makeup, or personal appearance to a more sexually suggestive or dramatically flamboyant style that is out of character for them. They may engage in activities that have a disorganized or bizarre quality (e.g., distributing candy, money, or advice to passing strangers). Gambling and antisocial behaviors may accompany the Manic Episode. Ethical concerns may be disregarded even by those who are typically very conscientious (e.g., a stockbroker inappropriately buys and sells stock without the clients' knowledge or permission; a scientist incorporates the findings of others). The person may be hostile and physically threatening to others. Some individuals, especially those with psychotic features, may become physically assaultive or suicidal. Adverse consequences of a Manic Episode (e.g., involuntary hospitalization, difficulties with the law, or serious financial difficulties) often result from poor judgment and hyperactivity. When no longer in the Manic Episode, most individuals are regretful for behaviors engaged in during the Manic Episode. Some individuals describe having a much sharper sense of smell, hearing, or vision (e.g., colors appear very bright). When catatonic symptoms (e.g., stupor, mutism, negativism, and posturing) are present, the specifier With Catatonic Features may be indicated (see p. 417).

Mood may shift rapidly to anger or depression. Depressive symptoms may last moments, hours, or, more rarely, days. Not uncommonly, the depressive symptoms and manic symptoms occur simultaneously. If the criteria for both a Major Depressive Episode and a Manic Episode are prominent every day for at least 1 week, the episode is considered to be a Mixed Episode (see p. 362). As the Manic Episode develops, there is often a substantial increase in the use of alcohol or stimulants, which may exacerbate or prolong the episode.

Associated laboratory findings. No laboratory findings that are diagnostic of a Manic Episode have been identified. However, a variety of laboratory findings have been noted to be abnormal in groups of individuals with Manic Episodes compared with control subjects. Laboratory findings in Manic Episodes include polysomnographic

abnormalities and increased cortisol secretion. There may be abnormalities involving the norepinephrine, serotonin, acetylcholine, dopamine, or gamma-aminobutyric acid neurotransmitter systems, as demonstrated by studies of neurotransmitter metabolites, receptor functioning, pharmacological provocation, and neuroendocrine function.

Specific Culture, Age, and Gender Features

Cultural considerations that were suggested for Major Depressive Episodes are also relevant to Manic Episodes (see p. 353). Manic Episodes in adolescents are more likely to include psychotic features and may be associated with school truancy, antisocial behavior, school failure, or substance use. A significant minority of adolescents appear to have a history of long-standing behavior problems that precede the onset of a frank Manic Episode. It is unclear whether these problems represent a prolonged prodrome to Bipolar Disorder or an independent disorder. See the corresponding sections of the texts for Bipolar I Disorder (p. 385) and Bipolar II Disorder (p. 394) for specific information on gender.

Course

The mean age at onset for a first Manic Episode is the early 20s, but some cases start in adolescence and others start after age 50 years. Manic Episodes typically begin suddenly, with a rapid escalation of symptoms over a few days. Frequently, Manic Episodes occur following psychosocial stressors. The episodes usually last from a few weeks to several months and are briefer and end more abruptly than Major Depressive Episodes. In many instances (50%–60%), a Major Depressive Episode immediately precedes or immediately follows a Manic Episode, with no intervening period of euthymia. If the Manic Episode occurs in the postpartum period, there may be an increased risk for recurrence in subsequent postpartum periods and the specifier With Postpartum Onset is applicable (see p. 422).

Differential Diagnosis

A Manic Episode must be distinguished from a **Mood Disorder Due to a General Medical Condition.** The appropriate diagnosis would be Mood Disorder Due to a General Medical Condition if the mood disturbance is judged to be the direct physiological consequence of a specific general medical condition (e.g., multiple sclerosis, brain tumor, Cushing's syndrome) (see p. 401). This determination is based on the history, laboratory findings, or physical examination. If it is judged that the manic symptoms are not the direct physiological consequence of the general medical condition, then the primary Mood Disorder is recorded on Axis I (e.g., Bipolar I Disorder) and the general medical condition is recorded on Axis III (e.g., myocardial infarction). A late onset of a first Manic Episode (e.g., after age 50 years) should alert the clinician to the possibility of an etiological general medical condition or substance.

A **Substance-Induced Mood Disorder** is distinguished from a Manic Episode by the fact that a substance (e.g., a drug of abuse, a medication, or exposure to a toxin) is judged to be etiologically related to the mood disturbance (see p. 405). Symptoms like

those seen in a Manic Episode may be precipitated by a drug of abuse (e.g., manic symptoms that occur only in the context of intoxication with cocaine would be diagnosed as Cocaine-Induced Mood Disorder, With Manic Features, With Onset During Intoxication). Symptoms like those seen in a Manic Episode may also be precipitated by antidepressant treatment such as medication, electroconvulsive therapy, or light therapy. Such episodes are also diagnosed as Substance-Induced Mood Disorders (e.g., Amitriptyline-Induced Mood Disorder, With Manic Features; Electroconvulsive Therapy–Induced Mood Disorder, With Manic Features). However, clinical judgment is essential to determine whether the treatment is truly causal or whether a primary Manic Episode happened to have its onset while the person was receiving the treatment (see p. 406).

Manic Episodes should be distinguished from **Hypomanic Episodes.** Although Manic Episodes and Hypomanic Episodes have an identical list of characteristic symptoms, the disturbance in Hypomanic Episodes is not sufficiently severe to cause marked impairment in social or occupational functioning or to require hospitalization. Some Hypomanic Episodes may evolve into full Manic Episodes.

Major Depressive Episodes with prominent irritable mood may be difficult to distinguish from Manic Episodes with irritable mood or from **Mixed Episodes.** This determination requires a careful clinical evaluation of the presence of manic symptoms. If criteria are met for both a Manic Episode and a Major Depressive Episode nearly every day for at least a 1-week period, this would constitute a Mixed Episode.

Attention-Deficit/Hyperactivity Disorder and a Manic Episode are both characterized by excessive activity, impulsive behavior, poor judgment, and denial of problems. Attention-Deficit/Hyperactivity Disorder is distinguished from a Manic Episode by its characteristic early onset (i.e., before age 7 years), chronic rather than episodic course, lack of relatively clear onsets and offsets, and the absence of abnormally expansive or elevated mood or psychotic features.

Criteria for Manic Episode

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary).

B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:

(1) inflated self-esteem or grandiosity
(2) decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
(3) more talkative than usual or pressure to keep talking
(4) flight of ideas or subjective experience that thoughts are racing
(5) distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)
(6) increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
(7) excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

C. The symptoms do not meet criteria for a Mixed Episode (see p. 365).

D. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

E. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).

Note: Manic-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of Bipolar I Disorder.

Mixed Episode

Episode Features

A Mixed Episode is characterized by a period of time (lasting at least 1 week) in which the criteria are met both for a Manic Episode and for a Major Depressive Episode nearly every day (Criterion A). The individual experiences rapidly alternating moods (sadness, irritability, euphoria) accompanied by symptoms of a Manic Episode (see p. 357) and a Major Depressive Episode (see p. 349). The symptom presentation frequently includes agitation, insomnia, appetite dysregulation, psychotic features, and suicidal thinking. The disturbance must be sufficiently severe to cause marked impairment in social or occupational functioning or to require hospitalization, or it is

characterized by the presence of psychotic features (Criterion B). The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism) (Criterion C). Symptoms like those seen in a Mixed Episode may be due to the direct effects of antidepressant medication, electroconvulsive therapy, light therapy, or medication prescribed for other general medical conditions (e.g., corticosteroids). Such presentations are not considered Mixed Episodes and do not count toward a diagnosis of Bipolar I Disorder. For example, if a person with recurrent Major Depressive Disorder develops a mixed symptom picture during a course of antidepressant medication, the diagnosis of the episode is Substance-Induced Mood Disorder, With Mixed Features, and there is no switch from a diagnosis of Major Depressive Disorder to Bipolar I Disorder. Some evidence suggests that there may be a bipolar "diathesis" in individuals who develop mixed-like episodes following somatic treatment for depression. Such individuals may have an increased likelihood of future Manic, Mixed, or Hypomanic Episodes that are not related to substances or somatic treatments for depression. This may be an especially important consideration in children and adolescents.

Associated Features and Disorders

Associated descriptive features and mental disorders. Associated features of a Mixed Episode are similar to those for Manic Episodes and Major Depressive Episodes. Individuals may be disorganized in their thinking or behavior. Because individuals in Mixed Episodes experience more dysphoria than do those in Manic Episodes, they may be more likely to seek help.

Associated laboratory findings. Laboratory findings for Mixed Episode are not well studied, although evidence to date suggests physiological and endocrine findings that are similar to those found in severe Major Depressive Episodes.

Specific Culture, Age, and Gender Features

Cultural considerations suggested for Major Depressive Episodes are relevant to Mixed Episodes as well (see p. 353). Mixed episodes appear to be more common in younger individuals and in individuals over age 60 years with Bipolar Disorder and may be more common in males than in females.

Course

Mixed Episodes can evolve from a Manic Episode or from a Major Depressive Episode or may arise de novo. For example, the diagnosis would be changed from Bipolar I Disorder, Most Recent Episode Manic, to Bipolar I Disorder, Most Recent Episode Mixed, for an individual with 3 weeks of manic symptoms followed by 1 week of both manic symptoms and depressive symptoms. Mixed episodes may last weeks to several months and may remit to a period with few or no symptoms or evolve into a Major Depressive Episode. It is far less common for a Mixed Episode to evolve into a Manic Episode.

Differential Diagnosis

A Mixed Episode must be distinguished from a **Mood Disorder Due to a General Medical Condition.** The diagnosis is Mood Disorder Due to a General Medical Condition if the mood disturbance is judged to be the direct physiological consequence of a specific general medical condition (e.g., multiple sclerosis, brain tumor, Cushing's syndrome) (see p. 401). This determination is based on the history, laboratory findings, or physical examination. If it is judged that the mixed manic and depressive symptoms are not the direct physiological consequence of the general medical condition, then the primary Mood Disorder is recorded on Axis I (e.g., Bipolar I Disorder) and the general medical condition is recorded on Axis III (e.g., myocardial infarction).

A **Substance-Induced Mood Disorder** is distinguished from a Mixed Episode by the fact that a substance (e.g., a drug of abuse, a medication, or exposure to a toxin) is judged to be etiologically related to the mood disturbance (see p. 405). Symptoms like those seen in a Mixed Episode may be precipitated by use of a drug of abuse (e.g., mixed manic and depressive symptoms that occur only in the context of intoxication with cocaine would be diagnosed as Cocaine-Induced Mood Disorder, With Mixed Features, With Onset During Intoxication). Symptoms like those seen in a Mixed Episode may also be precipitated by antidepressant treatment such as medication, electroconvulsive therapy, or light therapy. Such episodes are also diagnosed as Substance-Induced Mood Disorders (e.g., Amitriptyline-Induced Mood Disorder, With Mixed Features; Electroconvulsive Therapy–Induced Mood Disorder, With Mixed Features). However, clinical judgment is essential to determine whether the treatment is truly causal or whether a primary Mixed Episode happened to have its onset while the person was receiving the treatment (see p. 406).

Major Depressive Episodes with prominent irritable mood and **Manic Episodes with prominent irritable mood** may be difficult to distinguish from Mixed Episodes. This determination requires a careful clinical evaluation of the simultaneous presence of symptoms that are characteristic of both a full Manic Episode and a full Major Depressive Episode (except for duration).

Attention-Deficit/Hyperactivity Disorder and a Mixed Episode are both characterized by excessive activity, impulsive behavior, poor judgment, and denial of problems. Attention-Deficit/Hyperactivity Disorder is distinguished from a Mixed Episode by its characteristic early onset (i.e., before age 7 years), chronic rather than episodic course, lack of relatively clear onsets and offsets, and the absence of abnormally expansive or elevated mood or psychotic features. Children with Attention-Deficit/Hyperactivity Disorder also sometimes show depressive symptoms such as low self-esteem and frustration tolerance. If criteria are met for both, Attention-Deficit/Hyperactivity Disorder may be diagnosed in addition to the Mood Disorder.

Criteria for Mixed Episode

A. The criteria are met both for a Manic Episode (see p. 362) and for a Major Depressive Episode (see p. 356) (except for duration) nearly every day during at least a 1-week period.

B. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

C. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).

Note: Mixed-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of Bipolar I Disorder.

Hypomanic Episode

Episode Features

A Hypomanic Episode is defined as a distinct period during which there is an abnormally and persistently elevated, expansive, or irritable mood that lasts at least 4 days (Criterion A). This period of abnormal mood must be accompanied by at least three additional symptoms from a list that includes inflated self-esteem or grandiosity (nondelusional), decreased need for sleep, pressure of speech, flight of ideas, distractibility, increased involvement in goal-directed activities or psychomotor agitation, and excessive involvement in pleasurable activities that have a high potential for painful consequences (Criterion B). If the mood is irritable rather than elevated or expansive, at least four of the above symptoms must be present. This list of additional symptoms is identical to those that define a Manic Episode (see p. 357) except that delusions or hallucinations cannot be present. The mood during a Hypomanic Episode must be clearly different from the individual's usual nondepressed mood, and there must be a clear change in functioning that is not characteristic of the individual's usual functioning (Criterion C). Because the changes in mood and functioning must be observable by others (Criterion D), the evaluation of this criterion will often require interviewing other informants (e.g., family members). History from other informants is particularly important in the evaluation of adolescents. In contrast to a Manic Episode, a Hypomanic Episode is not severe enough to cause marked impairment in social or occupational functioning or to require hospitalization, and there are no psychotic features (Criterion E). The change in functioning for some individuals may take the form of a marked increase in efficiency, accomplishments, or creativity. However, for others, hypomania can cause some social or occupational impairment.

The mood disturbance and other symptoms must not be due to the direct physiological effects of a drug of abuse, a medication, other treatment for depression (electroconvulsive therapy or light therapy), or toxin exposure. The episode must also not be due to the direct physiological effects of a general medical condition (e.g., multiple sclerosis, brain tumor) (Criterion F). Symptoms like those seen in a Hypomanic Episode may be due to the direct effects of antidepressant medication, electroconvulsive therapy, light therapy, or medication prescribed for other general medical conditions (e.g., corticosteroids). Such presentations are not considered Hypomanic Episodes and do not count toward the diagnosis of Bipolar II Disorder. For example, if a person with recurrent Major Depressive Disorder develops symptoms of a hypomanic-like episode during a course of antidepressant medication, the episode is diagnosed as a Substance-Induced Mood Disorder, With Manic Features, and there is no switch from a diagnosis of Major Depressive Disorder to Bipolar II Disorder. Some evidence suggests that there may be a bipolar "diathesis" in individuals who develop manic- or hypomanic-like episodes following somatic treatment for depression. Such individuals may have an increased likelihood of future Manic or Hypomanic Episodes that are not related to substances or somatic treatments for depression.

The elevated mood in a Hypomanic Episode is described as euphoric, unusually good, cheerful, or high. Although the person's mood may have an infectious quality for the uninvolved observer, it is recognized as a distinct change from the usual self by those who know the person well. The expansive quality of the mood disturbance is characterized by enthusiasm for social, interpersonal, or occupational interactions. Although elevated mood is considered prototypical, the mood disturbance may be irritable or may alternate between euphoria and irritability. Characteristically, inflated self-esteem, usually at the level of uncritical self-confidence rather than marked grandiosity, is present (Criterion B1). There is very often a decreased need for sleep (Criterion B2); the person awakens before the usual time with increased energy. The speech of a person with a Hypomanic Episode is often somewhat louder and more rapid than usual, but is not typically difficult to interrupt. It may be full of jokes, puns, plays on words, and irrelevancies (Criterion B3). Flight of ideas is uncommon and, if present, lasts for very brief periods (Criterion B4).

Distractibility is often present, as evidenced by rapid changes in speech or activity as a result of responding to various irrelevant external stimuli (Criterion B5). The increase in goal-directed activity may involve planning of, and participation in, multiple activities (Criterion B6). These activities are often creative and productive (e.g., writing a letter to the editor, clearing up paperwork). Sociability is usually increased, and there may be an increase in sexual activity. There may be impulsive activity such as buying sprees, reckless driving, or foolish business investments (Criterion B7). However, such activities are usually organized, are not bizarre, and do not result in the level of impairment that is characteristic of a Manic Episode.

Associated Features and Disorders

Associated features of a Hypomanic Episode are similar to those for a Manic Episode. Mood may also be characterized as dysphoric if irritable or depressive symptoms are more prominent than euphoria in the clinical presentation.

Specific Culture and Age Features

Cultural considerations that were suggested for Major Depressive Episodes are relevant to Hypomanic Episodes as well (see p. 353). In younger (e.g., adolescent) persons, Hypomanic Episodes may be associated with school truancy, antisocial behavior, school failure, or substance use.

Course

A Hypomanic Episode typically begins suddenly, with a rapid escalation of symptoms within a day or two. Episodes may last for several weeks to months and are usually more abrupt in onset and briefer than Major Depressive Episodes. In many cases, the Hypomanic Episode may be preceded or followed by a Major Depressive Episode. Studies suggest that 5%–15% of individuals with hypomania will ultimately develop a Manic Episode.

Differential Diagnosis

A Hypomanic Episode must be distinguished from a **Mood Disorder Due to a General Medical Condition.** The diagnosis is Mood Disorder Due to a General Medical Condition if the mood disturbance is judged to be the direct physiological consequence of a specific general medical condition (e.g., multiple sclerosis, brain tumor, Cushing's syndrome) (see p. 401). This determination is based on the history, laboratory findings, or physical examination. If it is judged that the hypomanic symptoms are not the direct physiological consequence of the general medical condition, then the primary Mood Disorder is recorded on Axis I (e.g., Bipolar II Disorder) and the general medical condition is recorded on Axis III (e.g., myocardial infarction).

A **Substance-Induced Mood Disorder** is distinguished from a Hypomanic Episode by the fact that a substance (e.g., a drug of abuse, a medication, or exposure to a toxin) is judged to be etiologically related to the mood disturbance (see p. 405). Symptoms like those seen in a Hypomanic Episode may be precipitated by a drug of abuse (e.g., hypomanic symptoms that occur only in the context of intoxication with cocaine would be diagnosed as Cocaine-Induced Mood Disorder, With Manic Features, With Onset During Intoxication). Symptoms like those seen in a Hypomanic Episode may also be precipitated by antidepressant treatment such as medication, electroconvulsive therapy, or light therapy. Such episodes are also diagnosed as Substance-Induced Mood Disorders (e.g., Amitriptyline-Induced Mood Disorder, With Manic Features; Electroconvulsive Therapy–Induced Mood Disorder, With Manic Features). However, clinical judgment is essential to determine whether the treatment is truly causal or whether a primary Hypomanic Episode happened to have its onset while the person was receiving the treatment (see p. 406).

Manic Episodes should be distinguished from Hypomanic Episodes. Although Manic Episodes and Hypomanic Episodes have identical lists of characteristic symptoms, the mood disturbance in Hypomanic Episodes is not sufficiently severe to cause marked impairment in social or occupational functioning or to require hospitalization. Some Hypomanic Episodes may evolve into full Manic Episodes.

Attention-Deficit/Hyperactivity Disorder and a Hypomanic Episode are both

characterized by excessive activity, impulsive behavior, poor judgment, and denial of problems. Attention-Deficit/Hyperactivity Disorder is distinguished from a Hypomanic Episode by its characteristic early onset (i.e., before age 7 years), chronic rather than episodic course, lack of relatively clear onsets and offsets, and the absence of abnormally expansive or elevated mood.

A Hypomanic Episode must be distinguished from **euthymia,** particularly in individuals who have been chronically depressed and are unaccustomed to the experience of a nondepressed mood state.

Criteria for Hypomanic Episode

A. A distinct period of persistently elevated, expansive, or irritable mood, lasting throughout at least 4 days, that is clearly different from the usual nondepressed mood.

B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:

(1) inflated self-esteem or grandiosity
(2) decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
(3) more talkative than usual or pressure to keep talking
(4) flight of ideas or subjective experience that thoughts are racing
(5) distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)
(6) increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
(7) excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., the person engages in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

C. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the person when not symptomatic.

D. The disturbance in mood and the change in functioning are observable by others.

E. The episode is not severe enough to cause marked impairment in social or occupational functioning, or to necessitate hospitalization, and there are no psychotic features.

F. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).

Note: Hypomanic-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of Bipolar II Disorder.

Depressive Disorders

Major Depressive Disorder

Diagnostic Features

The essential feature of Major Depressive Disorder is a clinical course that is characterized by one or more Major Depressive Episodes (see p. 349) without a history of Manic, Mixed, or Hypomanic Episodes (Criteria A and C). Episodes of Substance-Induced Mood Disorder (due to the direct physiological effects of a drug of abuse, a medication, or toxin exposure) or of Mood Disorder Due to a General Medical Condition do not count toward a diagnosis of Major Depressive Disorder. In addition, the episodes must not be better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified (Criterion B).

The fourth digit in the diagnostic code for Major Depressive Disorder indicates whether it is a Single Episode (used only for first episodes) or Recurrent. It is sometimes difficult to distinguish between a single episode with waxing and waning symptoms and two separate episodes. For purposes of this manual, an episode is considered to have ended when the full criteria for the Major Depressive Episode have not been met for at least 2 consecutive months. During this 2-month period, there is either complete resolution of symptoms or the presence of depressive symptoms that no longer meet the full criteria for a Major Depressive Episode (In Partial Remission).

The fifth digit in the diagnostic code for Major Depressive Disorder indicates the current state of the disturbance. If the criteria for a Major Depressive Episode are met, the severity of the episode is noted as Mild, Moderate, Severe Without Psychotic Features, or Severe With Psychotic Features. If the criteria for a Major Depressive Episode are not currently met, the fifth digit is used to indicate whether the disorder is In Partial Remission or In Full Remission (see p. 412).

If Manic, Mixed, or Hypomanic Episodes develop in the course of Major Depressive Disorder, the diagnosis is changed to a Bipolar Disorder. However, if manic or hypomanic symptoms occur as a direct effect of antidepressant treatment, use of other medications, substance use, or toxin exposure, the diagnosis of Major Depressive Disorder remains appropriate and an additional diagnosis of Substance-Induced Mood Disorder, With Manic Features (or With Mixed Features), should be noted. Similarly, if manic or hypomanic symptoms occur as a direct effect of a general medical condition, the diagnosis of Major Depressive Disorder remains appropriate and an additional diagnosis of Mood Disorder Due to a General Medical Condition, With Manic Features (or With Mixed Features), should be noted.

Specifiers

If the full criteria are currently met for a Major Depressive Episode, the following specifiers may be used to describe the current clinical status of the episode and to describe features of the current episode:

Mild, Moderate, Severe Without Psychotic Features, Severe With Psychotic Features (see p. 411)
Chronic (see p. 417)
With Catatonic Features (see p. 417)
With Melancholic Features (see p. 419)
With Atypical Features (see p. 420)
With Postpartum Onset (see p. 422)

If the full criteria are not currently met for a Major Depressive Episode, the following specifiers may be used to describe the current clinical status of the Major Depressive Disorder and to describe features of the most recent episode:

In Partial Remission, In Full Remission (see p. 411)
Chronic (see p. 417)
With Catatonic Features (see p. 417)
With Melancholic Features (see p. 419)
With Atypical Features (see p. 420)
With Postpartum Onset (see p. 422)

The following specifiers may be used to indicate the pattern of the episodes and the presence of interepisode symptoms for Major Depressive Disorder, Recurrent:

Longitudinal Course Specifiers (With and Without Full Interepisode Recovery) (see p. 424)
With Seasonal Pattern (see p. 425)

Recording Procedures

The diagnostic codes for Major Depressive Disorder are selected as follows:

1. The first three digits are 296.
2. The fourth digit is either 2 (if there is only a single Major Depressive Episode) or 3 (if there are recurrent Major Depressive Episodes).
3. If the full criteria are currently met for a Major Depressive Episode, the fifth digit indicates the current severity as follows: 1 for Mild severity, 2 for Moderate severity, 3 for Severe Without Psychotic Features, 4 for Severe With Psychotic Features. If the full criteria are not currently met for a Major Depressive Episode, the fifth digit indicates the current clinical status of the Major Depressive Disorder as follows: 5 for In Partial Remission, 6 for In Full Remission. If the severity of the current episode or the current remission status of the disorder is unspecified, then the fifth digit is 0. Other specifiers for Major Depressive Disorder cannot be coded.

In recording the name of a diagnosis, terms should be listed in the following order: Major Depressive Disorder, specifiers coded in the fourth digit (e.g., Recurrent), specifiers coded in the fifth digit (e.g., Mild, Severe With Psychotic Features, In Partial Remission), as many specifiers (without codes) as apply to the current or most recent episode (e.g., With Melancholic Features, With Postpartum Onset), and as many

specifiers (without codes) as apply to the course of episodes (e.g., With Full Interepisode Recovery); for example, 296.32 Major Depressive Disorder, Recurrent, Moderate, With Atypical Features, With Seasonal Pattern, With Full Interepisode Recovery.

Associated Features and Disorders

Associated descriptive features and mental disorders. Major Depressive Disorder is associated with high mortality. Up to 15% of individuals with severe Major Depressive Disorder die by suicide. Epidemiological evidence also suggests that there is a fourfold increase in death rates in individuals with Major Depressive Disorder who are over age 55 years. Individuals with Major Depressive Disorder admitted to nursing homes may have a markedly increased likelihood of death in the first year. Among individuals seen in general medical settings, those with Major Depressive Disorder have more pain and physical illness and decreased physical, social, and role functioning.

Major Depressive Disorder may be preceded by Dysthymic Disorder (10% in epidemiological samples and 15%–25% in clinical samples). It is also estimated that each year approximately 10% of individuals with Dysthymic Disorder alone will go on to have a first Major Depressive Episode. Other mental disorders frequently co-occur with Major Depressive Disorder (e.g., Substance-Related Disorders, Panic Disorder, Obsessive-Compulsive Disorder, Anorexia Nervosa, Bulimia Nervosa, Borderline Personality Disorder).

Associated laboratory findings. The laboratory abnormalities that are associated with Major Depressive Disorder are those associated with Major Depressive Episode (see p. 352). None of these findings are diagnostic of Major Depressive Disorder, but they have been noted to be abnormal in groups of individuals with Major Depressive Disorder compared with control subjects. Neurobiological disturbances such as elevated glucocorticoid levels and EEG sleep alterations are more prevalent among individuals with Psychotic Features and those with more severe episodes or with Melancholic Features. Most laboratory abnormalities are state dependent (i.e., are present only when depressive symptoms are present). However, evidence suggests that some sleep EEG abnormalities persist into clinical remission or may precede the onset of the Major Depressive Episode.

Associated physical examination findings and general medical conditions. Individuals with chronic or severe general medical conditions are at increased risk to develop Major Depressive Disorder. Up to 20%–25% of individuals with certain general medical conditions (e.g., diabetes, myocardial infarction, carcinomas, stroke) will develop Major Depressive Disorder during the course of their general medical condition. The management of the general medical condition is more complex and the prognosis is less favorable if Major Depressive Disorder is present. In addition, the prognosis of Major Depressive Disorder is adversely affected (e.g., longer episodes or poorer responses to treatment) by concomitant chronic general medical conditions.

Specific Culture, Age, and Gender Features

Specific culture-related features are discussed in the text for Major Depressive Episode (see p. 353). Epidemiological studies suggest significant cohort effects in risk of depression. For example, individuals born between 1940 and 1950 appear to have an earlier age at onset and a greater lifetime risk of depression than those born prior to 1940. There is some evidence that Atypical Features are more common in younger people and that Melancholic Features are more common in older depressed people. Among those with an onset of depression in later life, there is evidence of subcortical white matter hyperintensities associated with cerebrovascular disease. These "vascular" depressions are associated with greater neuropsychological impairments and poorer responses to standard therapies. Major Depressive Disorder (Single or Recurrent) is twice as common in adolescent and adult females as in adolescent and adult males. In prepubertal children, boys and girls are equally affected.

Prevalence

Studies of Major Depressive Disorder have reported a wide range of values for the proportion of the adult population with the disorder. The lifetime risk for Major Depressive Disorder in community samples has varied from 10% to 25% for women and from 5% to 12% for men. The point prevalence of Major Depressive Disorder in adults in community samples has varied from 5% to 9% for women and from 2% to 3% for men. The prevalence rates for Major Depressive Disorder appear to be unrelated to ethnicity, education, income, or marital status.

Course

Major Depressive Disorder may begin at any age, with an average age at onset in the mid-20s. Epidemiological data suggest that the age at onset is decreasing for those born more recently. The course of Major Depressive Disorder, Recurrent, is variable. Some people have isolated episodes that are separated by many years without any depressive symptoms, whereas others have clusters of episodes, and still others have increasingly frequent episodes as they grow older. Some evidence suggests that the periods of remission generally last longer early in the course of the disorder. The number of prior episodes predicts the likelihood of developing a subsequent Major Depressive Episode. At least 60% of individuals with Major Depressive Disorder, Single Episode, can be expected to have a second episode. Individuals who have had two episodes have a 70% chance of having a third, and individuals who have had three episodes have a 90% chance of having a fourth. About 5%–10% of individuals with Major Depressive Disorder, Single Episode, subsequently develop a Manic Episode (i.e., develop Bipolar I Disorder).

Major Depressive Episodes may end completely (in about two-thirds of cases), or only partially or not at all (in about one-third of cases). For individuals who have only partial remission, there is a greater likelihood of developing additional episodes and of continuing the pattern of partial interepisode recovery. The longitudinal course specifiers With Full Interepisode Recovery and Without Full Interepisode Recovery (see p. 424) may therefore have prognostic value. A number of individuals have pre-

existing Dysthymic Disorder prior to the onset of Major Depressive Disorder, Single Episode. Some evidence suggests that these individuals are more likely to have additional Major Depressive Episodes, have poorer interepisode recovery, and may require additional acute-phase treatment and a longer period of continuing treatment to attain and maintain a more thorough and longer-lasting euthymic state.

Follow-up naturalistic studies suggested that 1 year after the diagnosis of a Major Depressive Episode, 40% of individuals still have symptoms that are sufficiently severe to meet criteria for a full Major Depressive Episode, roughly 20% continue to have some symptoms that no longer meet full criteria for a Major Depressive Episode (i.e., Major Depressive Disorder, In Partial Remission), and 40% have no Mood Disorder. The severity of the initial Major Depressive Episode appears to predict persistence. Chronic general medical conditions are also a risk factor for more persistent episodes.

Episodes of Major Depressive Disorder often follow a severe psychosocial stressor, such as the death of a loved one or divorce. Studies suggest that psychosocial events (stressors) may play a more significant role in the precipitation of the first or second episodes of Major Depressive Disorder and may play less of a role in the onset of subsequent episodes. Chronic general medical conditions and Substance Dependence (particularly Alcohol or Cocaine Dependence) may contribute to the onset or exacerbation of Major Depressive Disorder.

It is difficult to predict whether the first episode of a Major Depressive Disorder in a young person will ultimately evolve into a Bipolar Disorder. Some data suggest that the acute onset of severe depression, especially with psychotic features and psychomotor retardation, in a young person without prepubertal psychopathology is more likely to predict a bipolar course. A family history of Bipolar Disorder may also be suggestive of subsequent development of Bipolar Disorder.

Familial Pattern

Major Depressive Disorder is 1.5–3 times more common among first-degree biological relatives of persons with this disorder than among the general population. There is evidence for an increased risk of Alcohol Dependence in adult first-degree biological relatives, and there may be an increased incidence of an Anxiety Disorder (e.g., Panic Disorder, Social Phobia) or Attention-Deficit/Hyperactivity Disorder in the children of adults with Major Depressive Disorder.

Differential Diagnosis

See the "Differential Diagnosis" section for Major Depressive Episode (p. 354). A history of a **Manic, Mixed,** or **Hypomanic Episode** precludes the diagnosis of Major Depressive Disorder. The presence of Hypomanic Episodes (without any history of Manic Episodes) indicates a diagnosis of Bipolar II Disorder. The presence of Manic or Mixed Episodes (with or without Hypomanic Episodes) indicates a diagnosis of Bipolar I Disorder.

Major Depressive Episodes in Major Depressive Disorder must be distinguished from a **Mood Disorder Due to a General Medical Condition.** The diagnosis is Mood Disorder Due to a General Medical Condition if the mood disturbance is judged to be

the direct physiological consequence of a specific general medical condition (e.g., multiple sclerosis, stroke, hypothyroidism) (see p. 401). This determination is based on the history, laboratory findings, or physical examination. If it is judged that the depressive symptoms are not the direct physiological consequence of the general medical condition, then the primary Mood Disorder is recorded on Axis I (e.g., Major Depressive Disorder) and the general medical condition is recorded on Axis III (e.g., myocardial infarction). This would be the case, for example, if the Major Depressive Episode is considered to be the psychological consequence of having the general medical condition or if there is no etiological relationship between the Major Depressive Episode and the general medical condition.

A **Substance-Induced Mood Disorder** is distinguished from Major Depressive Episodes in Major Depressive Disorder by the fact that a substance (e.g., a drug of abuse, a medication, or exposure to a toxin) is judged to be etiologically related to the mood disturbance (see p. 405). For example, depressed mood that occurs only in the context of withdrawal from cocaine would be diagnosed as Cocaine-Induced Mood Disorder, With Depressive Features, With Onset During Withdrawal.

Dysthymic Disorder and Major Depressive Disorder are differentiated based on severity, chronicity, and persistence. In Major Depressive Disorder, the depressed mood must be present for most of the day, nearly every day, for a period of at least 2 weeks, whereas Dysthymic Disorder must be present for more days than not over a period of at least 2 years. The differential diagnosis between Dysthymic Disorder and Major Depressive Disorder is made particularly difficult by the fact that the two disorders share similar symptoms and that the differences between them in onset, duration, persistence, and severity are not easy to evaluate retrospectively. Usually Major Depressive Disorder consists of one or more discrete Major Depressive Episodes that can be distinguished from the person's usual functioning, whereas Dysthymic Disorder is characterized by chronic, less severe depressive symptoms that have been present for many years. If the initial onset of chronic depressive symptoms is of sufficient severity and number to meet criteria for a Major Depressive Episode, the diagnosis would be Major Depressive Disorder, Chronic (if the criteria are still met), or Major Depressive Disorder, In Partial Remission (if the criteria are no longer met). The diagnosis of Dysthymic Disorder is made following Major Depressive Disorder only if the Dysthymic Disorder was established prior to the first Major Depressive Episode (i.e., no Major Depressive Episodes during the first 2 years of dysthymic symptoms), or if there has been a full remission of the Major Depressive Episode (i.e., lasting at least 2 months) before the onset of the Dysthymic Disorder.

Schizoaffective Disorder differs from Major Depressive Disorder, With Psychotic Features, by the requirement that in Schizoaffective Disorder there must be at least 2 weeks of delusions or hallucinations occurring in the absence of prominent mood symptoms. Depressive symptoms may be present during **Schizophrenia, Delusional Disorder,** and **Psychotic Disorder Not Otherwise Specified.** Most commonly, such depressive symptoms can be considered associated features of these disorders and do not merit a separate diagnosis. However, when the depressive symptoms meet full criteria for a Major Depressive Episode (or are of particular clinical significance), a diagnosis of Depressive Disorder Not Otherwise Specified may be made in addition to the diagnosis of Schizophrenia, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified. Schizophrenia, Catatonic Type, may be difficult to distinguish from Major Depressive Disorder, With Catatonic Features. Prior history or family history may be helpful in making this distinction.

In elderly individuals, it is often difficult to determine whether cognitive symptoms (e.g., disorientation, apathy, difficulty concentrating, memory loss) are better accounted for by a **dementia** or by a Major Depressive Episode in Major Depressive Disorder. This differential diagnosis may be informed by a thorough general medical evaluation and consideration of the onset of the disturbance, temporal sequencing of depressive and cognitive symptoms, course of illness, and treatment response. The premorbid state of the individual may help to differentiate a Major Depressive Disorder from dementia. In dementia, there is usually a premorbid history of declining cognitive function, whereas the individual with Major Depressive Disorder is much more likely to have a relatively normal premorbid state and abrupt cognitive decline associated with the depression.

Diagnostic criteria for 296.2x Major Depressive Disorder, Single Episode

A. Presence of a single Major Depressive Episode (see p. 356).

B. The Major Depressive Episode is not better accounted for by Schizoaffective Disorder and is not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

C. There has never been a Manic Episode (see p. 362), a Mixed Episode (see p. 365), or a Hypomanic Episode (see p. 368). **Note:** This exclusion does not apply if all of the manic-like, mixed-like, or hypomanic-like episodes are substance or treatment induced or are due to the direct physiological effects of a general medical condition.

If the full criteria are currently met for a Major Depressive Episode, *specify* its current clinical status and/or features:

Mild, Moderate, Severe Without Psychotic Features/Severe With Psychotic Features (see p. 411)
Chronic (see p. 417)
With Catatonic Features (see p. 417)
With Melancholic Features (see p. 419)
With Atypical Features (see p. 420)
With Postpartum Onset (see p. 422)

If the full criteria are not currently met for a Major Depressive Episode, *specify* the current clinical status of the Major Depressive Disorder or features of the most recent episode:

In Partial Remission, In Full Remission (see p. 411)
Chronic (see p. 417)
With Catatonic Features (see p. 417)
With Melancholic Features (see p. 419)
With Atypical Features (see p. 420)
With Postpartum Onset (see p. 422)

Diagnostic criteria for 296.3x Major Depressive Disorder, Recurrent

A. Presence of two or more Major Depressive Episodes (see p. 356).

Note: To be considered separate episodes, there must be an interval of at least 2 consecutive months in which criteria are not met for a Major Depressive Episode.

B. The Major Depressive Episodes are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

C. There has never been a Manic Episode (see p. 362), a Mixed Episode (see p. 365), or a Hypomanic Episode (see p. 368). **Note:** This exclusion does not apply if all of the manic-like, mixed-like, or hypomanic-like episodes are substance or treatment induced or are due to the direct physiological effects of a general medical condition.

If the full criteria are currently met for a Major Depressive Episode, *specify* its current clinical status and/or features:

Mild, Moderate, Severe Without Psychotic Features/
Severe With Psychotic Features (see p. 411)
Chronic (see p. 417)
With Catatonic Features (see p. 417)
With Melancholic Features (see p. 419)
With Atypical Features (see p. 420)
With Postpartum Onset (see p. 422)

If the full criteria are not currently met for a Major Depressive Episode, *specify* the current clinical status of the Major Depressive Disorder or features of the most recent episode:

In Partial Remission, In Full Remission (see p. 411)
Chronic (see p. 417)
With Catatonic Features (see p. 417)
With Melancholic Features (see p. 419)
With Atypical Features (see p. 420)
With Postpartum Onset (see p. 422)

Specify:

Longitudinal Course Specifiers (With and Without Interepisode Recovery) (see p. 424)
With Seasonal Pattern (see p. 425)

300.4 Dysthymic Disorder

Diagnostic Features

The essential feature of Dysthymic Disorder is a chronically depressed mood that occurs for most of the day more days than not for at least 2 years (Criterion A). Individ-